

		FOR BHF USE			

LL2

Supportive Living Facility

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES
COST REPORT FOR
SUPPORTIVE LIVING FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE
THAT IS NECESSARY TO ACCOMPLISH THE
PURPOSE AS OUTLINED IN SECTION 146.2
CODE. DISCLOSURE OF THIS INFORMATION
FAILURE TO PROVIDE ANY INFORMATION
DUE DATE WILL RESULT IN CESSATION OF
PAYMENTS.

I. Facility ID Number: 1000066

Facility Name: Heritage Woods of Aledo

Address: 450 SE 13th Avenue Aledo 61231
Number City Zip Code

County: Mercer

Telephone Number: (309) 582-1132 Fax # ()

Federal Employer ID Number:

Date Current Owners were Certified: June 28, 2013

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT

☐ Charitable Corp.

☐ Trust

IRS Exemption Code

☐ PROPRIETARY

☐ Individual

☐ Partnership

☐ Corporation

☐ "Sub-S" Corp.

☒ Limited Liability Co.

☐ Trust

☐ Other

☐ GOVERNMENTAL

☐ State

☐ County

☐ Other

In the event there are further questions about this report, please contact:

Name: Bryan Starnes

Telephone Number: ((828) 261-7322)

Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICIAL

I have examined the contents of the accompanying report
State of Illinois, for the period from _____ to _____
and certify to the best of my knowledge and belief that the same
are true, accurate and complete statements in accordance with
instructions. Declaration of preparer (other than provider) is
information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information
in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____

(Type or Print Name) _____

(Title) _____

Paid
Preparer

(Signed) _____

(Print Name
and Title) _____

(Firm Name
& Address) _____

(Telephone) () _____ Fax _____

MAIL TO: BUREAU OF HEALTH FINANCE
IL DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone _____

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ERVICES
ie # (217) 782-1630

Facility Name Heritage Woods of Aledo Report Period Beginning: _____ Ending: _____

III. STATISTICAL DATA

A. Certified units; enter number of units and unit days

Date of change in certified units n/a

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	63	Single Unit Apartment	63	11,592	1
2		Double Unit Apartment			2
3		Other			3
4	63	TOTALS	63	11,592	4

B. Census-For the entire report period.

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	2,024	9,568		11,592	5
6	Double Unit					6
7	Other					7
8	TOTALS	2,024	9,568		11,592	8

C. Percent Occupancy. (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 100.00%

D. Indicate the number of paid bed-hold days the SLF had during this year
_____. Also, indicate the number of unpaid bed-hold days the SLF
had during this year. _____ (Do not include bed-hold days in Section B.)

E. Does page 3 include expenses for services or investments not directly related to SLF services?

YES ☐ NO ☒

F. Does the BALANCE SHEET reflect any non-SLF assets?

YES ☐ NO ☒

G. List all services provided by your facility for non-residents.
(E.g., day care, "meals on wheels", outpatient therapy)

H. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

I. Is your fiscal year identical to your tax year? ☒ YES ☐ NO

Tax Year: 2013 Fiscal Year: 2013

* All facilities other than governmental must report on the accrual basis.

J. Does the facility have any Illinois Housing Development Authority Loans outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

K. Does the facility have any loans from the Federal Home Loan Bank outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding? No If yes, did the facility make all of the required payments of interest and principle? _____
If no, explain. _____

Facility Name: Heritage Woods of Aledo

Report Period Beginning:

Ending:

IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
	A. General Services							
1	Dietary and Food Purchase	81,455	58,513	153	140,121		140,121	1
2	Housekeeping, Laundry and Maintenance	15,696	1,369	596	17,661		17,661	2
3	Heat and Other Utilities			21,649	21,649		21,649	3
4	Other (specify):							4
5	TOTAL General Services	97,151	59,882	22,398	179,431		179,431	5
	B. Health Care and Programs							
6	Health Care/ Personal Care	77,477		517	77,994		77,994	6
7	Activities and Social Services	8,670		499	9,169		9,169	7
8	Other (specify):							8
9	TOTAL Health Care and Programs	86,147		1,016	87,163		87,163	9
	C. General Administration							
10	Administrative and Clerical	68,720	2,807		71,527		71,527	10
11	Marketing Materials, Promotions and Advertising			8,504	8,504		8,504	11
12	Employee Benefits and Payroll Taxes			36,965	36,965		36,965	12
13	Insurance-Property, Liability and Malpractice			10,078	10,078		10,078	13
14	Other (specify): Management Fees			53,928	53,928		53,928	14
15	TOTAL General Administration	68,720	2,807	109,475	181,002		181,002	15
16	TOTAL Operating Expense (Sum of lines 5, 9 and 15)	252,018	62,689	132,889	447,596		447,596	16
	Capital Expenses							
	D. Ownership							
17	Depreciation			(176)	(176)		(176)	17
18	Interest							18
19	Real Estate Taxes			43,698	43,698		43,698	19
20	Rent -- Facility and Grounds			332,500	332,500		332,500	20
21	Rent -- Equipment							21
22	Other (specify):							22
23	TOTAL Ownership			376,022	376,022		376,022	23
24	GRAND TOTAL (Sum of lines 16 and 23)	252,018	62,689	508,911	823,618		823,618	24

Facility Name: Heritage Woods of Aledo

Report Period Beginning

Ending:

V. STAFFING AND SALARY COSTS (Please report each line separately.)

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1	\$ 9.00	1
2	Licensed Practical Nurses			2
3	Certified Nurse Assistants			3
4	Activity Director & Assistants	8	9.79	4
5	Social Service Workers			5
6	Head Cook	2	10.09	6
7	Cook Helpers/Assistants	1	14.42	7
8	Dishwashers			8
9	Maintenance Workers	1	13.00	9
10	Housekeepers	2	8.38	10
11	Laundry			11
12	Managers	1	13.78	12
13	Other Administrative			13
14	Clerical	3	8.25	14
15	Marketing	1	16.86	15
16	Other (Executive Director)	1	30.73	16
17	Total (lines 1 thru 16)	21	\$	17

VII. RELATED ORGANIZATIONS

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

RELATED SLF's & HEALTH CARE BUSINESSES

Name	1	City	2

OTHER RELATED BUSINESS ENTITIES

Name	3	City	4	Type of Business	5

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3?

YES

☐

NO

☒

Name of related entity:

If yes, what is the value of those services? \$

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties?

YES

☒

NO

☐

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1				\$	1
2					2
3					3
4					4
5					5
Total				\$	6

VI. (B) Management fees paid to unrelated parties

Amount of Fee

1		\$ 53,928	1
2			2
Total		\$ 53,928	3

Facility Name: Heritage Woods of Aledo Report Period Beginning: Ending:

VIII. OWNERSHIP COSTS

A. Purchase price of land \$ Year land was acquired

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar. *Total units on this schedule must agree with page 2.

	1 Units*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Computer		2013		\$ 516	\$ 14	3	\$ 14	\$ (0)	\$ 72	1
2	PTAC Pump		2013		1,394	23	5	23	(0)	93	2
3	PTAC Pump		2013		708	12	5	12	0	12	3
4											4
5											5
	Improvement Type										
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17	TOTAL (lines 1 thru 16)				\$ 2,618	\$ 49		\$ 49	\$ (0)	\$ 177	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$	\$	\$	\$		\$	18
19	Vehicles							19
20	TOTAL (lines 18 and 19)	\$	\$	\$	\$		\$	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: Heritage Woods of Aledo Report Period Beginning: Ending:

IX. RENTAL COSTS

A. Building and Fixed Equipment

1. Name of Party Holding Lease: Cornerstone

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? [x] YES [] NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building		66	6/28/2013	\$ 332,500	15	5	3
4	Additions			/ /				4
5				/ /				5
6				/ /				6
7	TOTAL				\$ 332,500			7

8. Is movable equipment rental included in building rental?
[] YES [x] NO

9. Rental amount for movable equipment \$

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

X. INTEREST EXPENSE

	1	2		3	4	6		7	8	9	
	Name of Lender	Related**		Purpose of Loan	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
		YES	NO			Original	Balance				
	A. Directly Facility Related										
	Long-Term										
1					/ /	\$	\$	/ /		\$	1
2					/ /			/ /			2
3					/ /			/ /			3
	Working Capital										
4					/ /			/ /			4
5					/ /			/ /			5
6					/ /			/ /			6
7	TOTAL Facility Related					\$	\$			\$	7
	B. Non-Facility Related										
8					/ /			/ /			8
9					/ /			/ /			9
10	TOTALS (lines 7, 8 and 9)					\$	\$			\$	10

* If there is an option to buy the building, please provide complete details on an attached schedule.
** If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: Heritage Woods of Aledo

Report Period Beginning: 6/28/2014

Ending: 12/31/2013

XI. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/13

(last day of reporting year)

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 191,641	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	110,781		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,180		6
7	Other Prepaid Expenses	10,079		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 316,681	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 316,681	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 226,927	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,391		30
31	Accrued Taxes Payable			31
32	Accrued Interest Payable			32
33	Deferred Compensation	94,822		33
34	Federal and State Income Taxes			34
	Other Current Liabilities(specify):			
35				35
36				36
37	TOTAL Current Liabilities (sum of lines 26 thru 36)	\$ 353,140	\$	37
	D. Long-Term Liabilities			
38	Long-Term Notes Payable			38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	Other Long-Term Liabilities(specify):			
42				42
43				43
44	TOTAL Long-Term Liabilities (sum of lines 38 thru 43)	\$	\$	44
45	TOTAL LIABILITIES (sum of lines 37 and 44)	\$ 353,140	\$	45
46	TOTAL EQUITY	\$	\$	46
47	TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)	\$ 353,140	\$	47

*(See instructions.)

Facility Name: Heritage Woods of Aledo

Report Period Beginning: 6/28/2013

Ending:

12/31/2014

XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

	Revenue	Amount	
	A. SLF Resident Care		
1	Gross SLF Resident Revenue	\$ 1,061,773	1
2	Discounts and Allowances	(500)	2
3	SUBTOTAL Resident Care (line 1 minus line 2)	\$ 1,061,273	3
	B. Other Operating Revenue		
4	Special Services		4
5	Other Health Care Services	16,289	5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	SUBTOTAL OTHER OPERATING REVENUE (sum of lines 4 thru 10)	\$ 16,289	11
	C. Non-Operating Revenue		
12	Contributions		12
13	Interest and Other Investment Income		13
14	SUBTOTAL Non-Operating Revenue (sum of lines 12 and 13)	\$	14
	D. Other Revenue (specify):		
15			15
16			16
17	SUBTOTAL Other Revenue (sum of lines 15 and 16)	\$	17
18	TOTAL REVENUE (sum of lines 3, 11, 14 and 17)	\$ 1,077,562	18

	Expenses	Amount	
	A. Operating Expenses		
19	General Services	388,857	19
20	Health Care/ Personal Care	87,612	20
21	General Administration	198,033	21
	B. Capital Expense		
22	Ownership	332,676	22
	C. Other Expenses		
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	TOTAL EXPENSES (sum of lines 19 thru 27)	\$ 1,007,178	28
29	Income Before Income Taxes (line 18 minus line 28)	\$ 70,384	29
30	Income Taxes	\$	30
31	NET INCOME OR LOSS FOR THE YEAR (line 29 minus line 30)	\$ 70,384	31

